03.10450 MAXIMUM PAYMENT TO HOSPITALS. Pursuant to the provisions of Title XIX of the Social Security Act, in reimbursing hospitals, the Department will pay in behalf of MA recipients the lesser of customary charges or the reasonable cost of inpatient services in accordance with the procedures detailed in Idaho Department of Health and Welfare Rules and Regulations Sections 03.10450 -- 03.10499. The upper limits observed by the Department in reimbursing each individual hospital must not exceed the payment which would be determined as a reasonable cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement. (7-1-87)

03.10451 EXEMPTION OF NEW HOSPITALS. A hospital that has operated as the type of facility for which it is certified (or the equivalent thereof) under present and previous ownership for less than three (3) full years will be paid in accordance with the Title XVIII principles of reimbursement, including those provisions applicable to new providers for the carryover and recovery of unreimbursed costs, pursuant to 42 CFR Subpart D, Section 405.344(d) and Subpart C, Section 413.30(g) and (h). (7-1-87)

03.10452, REPORTING PERIODS. Any hospital cost reporting period which: (1-16-80)

01. Current Year. Any hospital cost reporting period for which reasonable cost is being determined will be termed the "current year." (7-1-87)

02. Principal Year. For services rendered after the effective date of this regulation, the "principal year" shall be the provider's fiscal year ending in calendar year 1984 in which a finalized Medicare cost report or its equivalent is prepared for Title XIX cost settlement. (7-1-87)

03. Base Year. For services rendered prior to the effective date of this regulation, the "base year" is the most recent available provider fiscal year in which a finalized Medicare cost report has been issued by the Intermediary. Providers with fiscal years which are split between the base year and the principal year may not be exempt from the regulations governing the Title XIX per cost limitations in effect any time during the current year. The per admission costs related to the base year will be adjusted by the volume adjustment formula using the current year's total admissions under the regulations in effect prior to the enactment of these regulations. The admissions and related services provided after the effective date of these regulations during the current year will

be governed by these regulations. (7-1-87)

03.10453, BASIS OF PAYMENT. In determining reimbursement on the basis either of customary charges or of the reasonable cost of inpatient services under Medicaid guidelines, whichever is the lesser, the following will apply: (7-1-87)

01. Reasonable Costs. Reasonable cost includes all necessary and ordinary costs incurred in rendering the services related to patient care which a prudent and cost-conscious hospital would pay for a given item or service which do not exceed the Title XIX cost limit. (7-1-87)

02. Allowable Costs. The current year's Title XIX apportionment of a hospital's allowable costs determined at final settlement consist of those costs permitted by the principles of reimbursement contained in the Medicare Health Insurance Manual Parts I and II (HIM-15-I & II) and do not include costs already having payment limited by Medicaid rate file or any other Medicaid charge limitation. (7-1-87)

03. Apportioned Costs. Apportioned costs consist of the share of a hospital's total allowable costs attributed to Medicaid program recipients and other patients so that the share borne by the program is based upon actual services received by program recipients, as set forth in the applicable Title XVIII principles of cost reimbursement as specified in Health Insurance Manual, HIM-15, and in compliance with Medicaid reimbursement regulations. (7-1-87)

04. Capital Costs. For the purposes of hospital reimbursement, capital costs are those allowable costs considered in the final settlement that represent the cost to each hospital for its reasonable property related and financing expense, and property taxes. (7-1-87)

12/1/87 2/1/87

05. Operating Costs. For the purposes of hospital reimbursement, operating costs are the allowable costs included in the cost centers established in the finalized Medicare cost report to accumulate costs applicable to providing routine and ancillary services to patients for the purposes of cost assignment and allocation in the step-down process. (7-1-87)

87-4 12-15-

06. Other Allowable Costs. Other allowable costs are those reasonable costs recognized under the

Medicaid reasonable cost principles for services not subject to Medicaid limitations of coverage or reimbursement limits. Costs which are not reimbursed as operating costs, but recognized by Medicare principles as allowable costs will be included in the total reasonable costs. Other allowable costs include, but are not necessarily limited to, physician's component which was combined-billed, capital costs, ambulance costs, excess costs carry-forwards, and medical education costs. (7-1-87)

07. Customary Charges. Customary charges reflect the regular rates for inpatient or outpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services are related to the cost of services billed to the Title XIX program. No more than one hundred percent (100%) of covered charges will be reimbursed for the separate operating costs for either total inpatient services or total outpatient services at the time of final cost settlement for any fiscal year. (7-1-87)

03.10454, TITLE XIX COST LIMITS. In the determination of reasonable costs, a separate Title XIX cost limit for the services rendered prior to, and after, the effective date of this regulation, as designated in the approved state plan for hospitals in effect, will not exceed the costs of a economically and efficiently operated facility as constrained by the Title XIX cost limit in effect during that period of service. (7-1-87)

01. Title XIX Cost Limit Prior to Effective Date of Regulations. The reimbursable reasonable costs for services rendered prior to the effective date of this regulation will be determined by the regulations in effect at the time. (7-1-87)

12/1/87
2/1/87

02. Title XIX Cost Limit After Effective Date of Regulations. In the determination of a hospital's reasonable costs for inpatient services rendered after the effective date of this regulation, a Hospital Cost Index, computed for each hospital, will be applied to the operating costs, excluding capital costs and other allowable costs (see Idaho Department of Health and Welfare Rules and Regulations Section 03.10353,06.) of the principal year and adjusted on a per diem basis for each subsequent year under the Hospital Cost Index. (7-1-87)

S1-4
11-5

a. The Hospital Cost Index will be the national forecast of the Hospital Market Basket of

total operating costs, excluding capital costs, as reported by Data Resources Incorporated (DRI) health care costs as the percent moving average in the most recent index available before final settlement is completed. (7-1-87)

b. Each inpatient routine service cost center, as reported in the finalized 1984 fiscal year end Medicare cost report, will be segregated in the Title XIX cost limit calculation and assigned a share of total Title XIX inpatient ancillary costs. The prorated ancillary costs shall be determined by the ratio of each Title XIX routine cost center's reported costs to total Title XIX inpatient routine service costs in the principal year. (7-1-87)

c. Each routine cost center's total Title XIX routine service costs plus the assigned share of Title XIX inpatient ancillary costs of the principal year will be divided by the related Title XIX patient days to identify the total costs per diem in the principal year.(7-1-87)

i. The related inpatient routine service cost center's per diem capital and medical education costs plus the prorated share of inpatient ancillary capital costs will be subtracted from the per diem amount identified in Idaho Department of Health and Welfare Rules and Regulations Section 03.10454,02.b. to identify each inpatient routine service cost center per diem cost limit in the principal year. (7-1-87)

ii. If a provider did not have any Title XIX inpatient utilization or render any Title XIX inpatient services in an individual inpatient routine service cost center in its fiscal year ending in 1984, the principal year for only those routine cost centers without utilization in the provider's 1984 fiscal year will be appropriately calculated using the information available in the next subsequent year in which Title XIX utilization occurred. (7-1-87)

d. Claims with dates of admission prior to July 1, 1987, which include services on July 1, 1987, and thereafter will be reimbursed under

the regulations in effect prior to the effective date of this regulation. (7-1-87)

e. Each routine cost center's cost per diem for the principal year will be multiplied by a Hospital Cost Index for each subsequent fiscal year. (7-1-87)

f. The sum of the per diem cost limits for the Title XIX inpatient routine service cost centers of a hospital during the principal year, as adjusted by the Hospital Cost Index, will be the Title XIX cost limit for operating costs in the current year. (7-1-87)

i. At the date of final settlement, reimbursement of the Title XIX current year inpatient routine cost centers plus the assigned ancillary costs will be limited to the total 1984 per diem operating costs as adjusted for each subsequent fiscal year after the principal year through the current year by the Hospital Cost Index. (7-1-87)

ii. For fiscal years ending after the effective date of this regulation, the provider will be notified of an estimated Hospital Cost Index (HCFA Market Basket Index) prior to final settlement only upon written request. (7-1-87)

03.10455, EXCEPTIONS TO TITLE XIX COST LIMIT. A request by a provider for review by the Bureau of Medical Assistance concerning an adjustment to or exemption from the cost limits imposed under the provisions set forth in Idaho Department of Health and Welfare Rules and Regulations Sections 03.10450 -- 03.10499, can be made to the Bureau of Medical Assistance under the following circumstances (see also Idaho Department of Health and Welfare Rules and Regulations Section 03.10459): (7-1-87)

01. Exception Because of Extraordinary Circumstances. Where a provider's costs exceed the Title XIX limit due to extraordinary circumstances beyond the control of the provider, the provider can request an adjustment to the cost limit to the extent the provider proves such higher costs result from the extraordinary circumstances including, but not limited to, increased costs attributable to strikes, fires, earthquake, flood, or similar, unusual occurrences with substantial cost effects. (7-1-87)

02. Adjustment for Hospitals Serving a Disproportionate Share of Low Income Patients. Where a provider's cost exceeds the Title XIX cost limit and has been granted special treatment by HCFA under the criteria set forth in 42 CFR Subpart B, Section 412.106, a per diem adjustment will be made to the Title XIX cost limit for patient days occurring after the effective date of this regulation during the provider's fiscal year which qualifies for the adjustment. The cost limit adjustment factor will be the percentage increase allowed by HCFA. (7-1-87)

03. Adjustment to the Proration of Ancillary Costs in the Principal Year. Where the provider asserts that the proration of ancillary costs does not adequately reflect the total Title XIX cost per diem calculated for the inpatient routine service cost centers in the principal year, the provider may submit a detailed analysis of ancillary services provided to each Title XIX recipient for each type of patient day during each recipient's stay during the principal year. The provider will be granted this adjustment only once upon appeal prior to notice of program reimbursement for the provider's fiscal year ending after the effective date of these regulations. (7-1-87)

03.10456, OUT-OF-STATE HOSPITALS

01. Cost Settlements for Certain Out-of-State Hospitals. Hospitals not located in the State of Idaho will have a cost settlement computed with the State of Idaho if the following conditions are met: (7-1-87)

a. Total inpatient and outpatient covered charges are more than twenty thousand dollars ($20,000); or (7-1-87)

b. When less than twenty thousand dollars ($20,000) of covered charges are billed to the state by the provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department. (7-1-87)

02. Payment for Hospitals Without Cost Settlement. Those out-of-state hospitals not cost settling with the state will have annually adjusted rates

of payment no greater than seventy-five (75%) for inpatient covered charges and no greater than eighty percent (80%) of outpatient covered charges or, the average inpatient and outpatient reimbursement rates paid to Idaho hospitals. (7-1-87)

03.10457 AUDIT FUNCTION. Under a common audit agreement, the Medicare Intermediary may perform any audit required for both Title XVIII and Title XIX purposes. The Department may elect to perform an audit even though the Medicare Intermediary does not choose to audit the facility. (7-1-87)

03.10458 ADEQUACY OF COST INFORMATION. Cost information as developed by the provider must be current, accurate, and in sufficient detail and in such form as needed to support payments made for services rendered to recipients. This includes all ledgers, books, reports, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable costs, leaving an audit trail capable of being audited. Financial and statistical records will be maintained in a consistent manner from one (1) settlement period to another. (7-1-87)

03.10459 AVAILABILITY OF RECORDS OF HOSPITAL PROVIDERS. A participating hospital provider of services must make available to the Department, the provider s fiscal and other necessary records in the state in which the facility is licensed for the purpose of determining its ongoing recordkeeping capability and to ascertain information pertinent to the determination of the proper amount of program payments due the provider. (7-1-87)

03.10460, NOTICE OF PROGRAM REIMBURSEMENT. Following receipt of the finalized Medicare cost report and the timely receipt of any other information requested by the Department to fairly cost settle with the provider, a certified letter with the return receipt requested will be sent to the provider which sets forth the amounts of underpayment or overpayment made to the provider. The notice of the results of the final retroactive adjustment shall be sent even though the provider intends to request a hearing on the determination, or has appealed the Medicare Intermediary's determination of cost settlement. Where the determination shows that the provider is indebted to the Title XIX program because total interim and other payments exceed costs, the state will take the necessary action to recover overpayment, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. Such action of recovery or suspension will con-

tinue even after a request for an informal conference or hearing is filed with the state. If the hearing results in a revised determination, appropriate adjustments will be made to the settlement amount. (7-1-87)

01. Timing of Notice. The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the cost report from the Medicare Intermediary. (7-1-87)

02. Reopening of Completed Settlements. A Medicaid completed cost settlement may be reopened by the provider or the state within a three (3) year period from the date of the letter of notice of program reimbursement. The issues must have been raised, appealed and resolved through the reopening of the cost report by the Medicare Intermediary. Issues previously addressed and resolved by the Department's appeal process are not cause for reopening of the finalized cost settlement. (7-1-87)

03.10461, INTEREST CHARGES ON OVERPAYMENTS AND UNDERPAYMENTS TO HOSPITALS. The Title XIX program will charge interest on overpayments, and pay interest on underpayments, to hospitals as follows: (7-1-87)

01. Interest After Sixty Days of Notice. If full repayment from the indebted party is not received within sixty (60) days after the provider has received notice of program reimbursement, interest will accrue from the date of receipt of the notice of program reimbursement as defined in Idaho Department of Health and Welfare Rules and Regulations Section 03.10460, and will be charged on the unpaid settlement balance for each thirty (30) day period that payment is delayed. Periods of less than thirty (30) days will be treated as a full thirty (30) day period, and the thirty (30) day interest charge will be applied to any unpaid balance. Each payment will be applied first to accrued interest, then to the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not an allowable interest expense. (7-1-87)

12/1/87 7/1/87

02. Waiver of Interest Charges. When the Department determines an overpayment exists, it may waive interest charges if it determines that the administrative costs of collecting them exceed the charges. (7-1-87)

03. Rate of Interest. The interest rate on overpayments and underpayments will be the statutory rate as set forth in Section 28-22-104(1), Idaho Code,

87-4 7-1-87

compounded monthly. (7-1-87)

04. Retroactive Adjustment. The balance and interest shall be retroactively adjusted to equal the amounts that would have been due based on any changes which occur as a result of the final determination in the administrative appeal and judicial appeal process. Interest penalties shall only be applied to unpaid amounts and shall be subordinated to final interest determinations made in the judicial review process. (7-1-87)

03.10462, RECOVERY METHODS. Recovery shall be effected by one of the following methods: (7-1-87)

01. Lump Sum Voluntary Repayment. Pursuant to the provider's receipt of the notice of program reimbursement, the provider refunds the entire overpayment to the Department. (7-1-87)

02. Periodic Voluntary Repayment. The provider shall request in writing that recovery of the overpayment be made over a period of twelve (12) months or less. The provider must adequately document the request by demonstrating that the financial integrity of the provider would be irreparably compromised if repayments occurred over a shorter period of time than requested. (7-1-87)

03. Department Initiated Recovery. The Department shall recover the entire unpaid balance of the overpayment of any settlement amount in which the provider does not respond to the notice of program reimbursement within thirty (30) days of receipt. (7-1-87)

04. Recovery from Medicare Payments. The Department may request that Medicare payments be withheld in accordance with Title 42, CFR, Subpart C, Section 405.375. (7-1-87)

03.10463 NONAPPEALABLE ITEMS. The formula for the determination of the Hospital Cost Index, the principles of reimbursement which define allowable cost, non-Medicaid program issues, interim rates which are in compliance with state and federal regulations, and the preliminary adjustments prior to final cost settlement determinations as supported by properly completed cost reports and audits must not be accepted as appealable items. (7-1-87)

03.10464, INTERIM REIMBURSEMENT RATES. The interim reimbursement rates are reasonable and adequate to meet the necessary costs which must be incurred by economically and efficiently operated providers which provide services in

conformity with applicable state and federal laws, regulations, and quality and safety standards. (7-1-87)

01. Annual Adjustments. Interim rates will be adjusted at least annually based on the best information available to the Department. (7-1-87)

02. Retrospective Adjustments. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. (7-1-87)

03. Basis for Adjustments. The Department may make an adjustment based on the Medicare cost report as submitted and accepted by the Intermediary after the provider's reporting year to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement. (7-1-87)

04. Unadjusted Rate. The Title XIX interim reimbursement rate on file is synonymous with the term "unadjusted rate" used by other payors. (7-1-87)

03.10465 HOSPITAL SWING-BED REIMBURSEMENT. The Department will reimburse hospitals which meet the requirements found in Idaho Department of Health and Welfare Rules and Regulations Section 03.5161 governing Medical Assistance. (7-1-87)

03.10466 -- 03.10499 (RESERVED)

03.10500, DISPUTED PAYMENTS TO HOSPITALS. If a hospital has a grievance or complaint or requests an exception to the requirements of Idaho Department of Health and Welfare Rules and Regulations Sections 03.10450 -- 03.10499, the hospital can invoke the following procedures: (1-16-80)

01. Filing of Dispute. Within thirty (30) days after a provider receives notification of an action or determination, and it has any grievance, complaint, or exception, the provider must identify in writing to the Bureau of Medical Assistance the specific issues involved and specifically describe the disputed action or inaction regarding such issue(s) and the grounds for its contention that an action or determination was erroneous. Any information and copies of any documentation on which the facility intends to rely to support its position shall be included with the initial filing of the dispute. (7-1-87)

02. Initial Response to the Dispute. The Bureau of Medical Assistance will acknowledge the written grievance, complaint, or exception and transmit